	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Yorkshire Ambulance Service, Trust Headquarters, Brindley Way, Wakefield 41 Business Park, Wakefield, WF2 0XQ**
1	**CORONER** I am David Urpeth, assistant coroner, for the coroner area of South Yorkshire West
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 3.10.18, an investigation into the death of Arthur William Jepson was commenced. The investigation concluded at the end of the inquest on 16.9.19. The conclusion of the inquest was Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Mr Jepson suffered stomach pain and called 999. The evidence was that the initial call was made at 15.32. That call was initially triaged as Category 5 but when the paramedic telephoned an hour later the matter was re classified at category 3. The ambulance arrived at 19.31. .
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – During the inquest, evidence showed:- 1. that the pressure on resources was high that day. 2. that a review at the two hour point should have taken place to ascertain if the matter needed re categorisation. 3. Such a review didn't happen. 4. Whilst the evidence at inquest was that this is unlikely to have changed the outcome in this case, it was a concern to me that it could be in another case.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th November 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner to all Interested Persons :- The family of Mr Jepson, the deceased. CQC I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**16.9.19** **SIGNED BY: DAVID URPETH, ASSISTANT CORONER**